CDC Press Releases

CDC Telebriefing on Ebola outbreak in West Africa

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Press Briefing Transcript

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- Audio recording[MP3, 15.7 MB](https://www.cdc.gov/media/releases/2014/t0728-ebola.mp3)
  Telebriefing starts at the 36 minute mark.

TOM SKINNER: Thank you, Rebecca, and thank you all for joining us today for a update on the ongoing Ebola outbreak in Africa. With us today is the deputy director of CDC's National Center for Emerging Zoonotic and Infectious Diseases, Stephan Monroe. He will provide some opening remarks and then we will progress to your questions.

STEPHAN MONROE: Thank you, for the last few months, the CDC and World Health Organization and other partners have been actively engaged in response to the Ebola outbreak in west Africa. Since the first report surface in March, there have been more than 1,201 cases reported and unfortunately 672 deaths in Guinea, Liberia and Sierra Leone. This is the largest Ebola outbreak in history and the first in West Africa. It's a rapidly changing situation and we expect there will be more cases in these countries in the coming weeks and months. The response to this outbreak will be more of a marathon than a sprint.

I want to underscore that Ebola poses little risk to the U.S. general population. Transmission is through direct contact of bodily fluids of an infected person or exposure objects like needles that have been contaminated with infected secretions. Individuals who are not symptomatic are not contagious. The mortality rate in some outbreaks can be as high as 90 percent, but in this outbreak, it is currently around 60 percent, indicating that some of our early treatment efforts may be having an impact.

The CDC has deployed several teams to the region since the outbreak began. We currently have 12 staff deployed in Guinea (5), Sierra Leone (1), and Liberia (6) helping to coordinate the response at the national level, providing health education and assisting with database management. Our staff are also arranging and training teams of people who can do contact tracing- interviewing those who may have been in contact with ill patients to see if they have symptoms. We have partially activated our Emergency Operations Center to help coordinate Ebola technical assistance activities with our international and federal partners. And CDC is

in regular communication with our international partners- the World Health Organization and Doctors without Borders – regarding the outbreak, as well as the Ministries of Health in Guinea, Liberia and Sierra Leone.

This past Friday, the Nigerian Ministry of Health confirmed that a man in the country's capital, Lagos, died from Ebola infection. The man had been in isolation in the hospital since arriving at the Lagos airport from Liberia, where he apparently contracted the infection. Health authorities are currently investigating whether passengers or crew on the plane or other people who had contact with the ill traveler are at risk for infection.

As you may have also heard, two American healthcare workers at a hospital in Monrovia, Liberia, have been infected with Ebola virus. One of the healthcare worke
rs, a physician who worked with Ebola patients in the hospital, is symptomatic and in isolation. The other health care worker developed fever but no other signs of illness. The physician's family had been living with him in Liberia. Thankfully, the family members had returned to the United States before the doctor got sick and therefore are not at risk for contracting Ebola or spreading it to anyone here. Out of an abundance of caution, the family is currently on a 21 day fever watch. I want to emphasize that Ebola isn't contagious until symptoms appear.

No Ebola cases have been reported in the United States and the likelihood of this outbreak spreading outside of West Africa is very low. It's more likely that the countries surrounding Guinea, Liberia, and Sierra Leone may see cases because of the wide geographic spread of this outbreak.

While it's possible that someone could become infected with the Ebola virus in Africa and then get on a plane to the United States, it's very unlikely that they would be able to spread the disease to fellow passengers. The Ebola virus spreads through direct contact with the blood, secretions, or other body fluids of ill people, and indirect contact – for example with needles and other things that may be contaminated with these fluids.Most people who become infected with Ebola are those who live with and care for people who have already caught the disease and are showing symptoms.

Nevertheless, because people do travel between West Africa and the U.S., CDC needs to be prepared for the very remote possibility that one of those travelers could get Ebola and return to the U.S. while sick. We are actively working to educate American healthcare workers about how to isolate patients and how they can protect themselves from infection. Today, we are sending out a Health Alert Notice to remind U.S. healthcare workers of the importance of taking steps to prevent the spread of this virus.

CDC encourages all U.S. healthcare providers to:

1. Take good travel histories of their patients to identify any who have traveled to West Africa within the last three weeks.
2. Know the symptoms of Ebola — fever, headache, joint and muscle aches, weakness, diarrhea, vomiting, stomach pain and lack of appetite and in some cases bleeding.
3. Know what to do if you have a patient who has Ebola symptoms:
    - First, properly isolate the patient.

- Then, follow infection control precautions to prevent the spread of Ebola. Most importantly, avoid contact with blood and body fluids of infected people.

CDC has issued a level 2 travel notice for these 3 countries. We recommend that travelers "avoid contact with blood and body fluids of infected people to protect themselves." We have more detailed information on our Traveler's Health website, which is www.cdc.gov/travel.

I'd like to close by reminding everyone that global health security – keeping the U.S. and the world safe and secure from infectious disease threats – is achieved by preventing, detecting and responding to outbreaks as early and effectively as possible.

Over the next five years the United States has committed to working with at least 30 partner countries (totaling at least 4 billion population) to improve their ability to prevent, detect, and effectively respond to infectious disease threats – whether naturally occurring or caused by accidental or intentional release of pathogens.

- Improving these capabilities for each nation improves health security for all nations. Stopping outbreaks where they occur is the most effective and least expensive way to protect people's health.
- The President's FY 2015 budget includes a request of $45 million to fund this global health security effort, The Global Health Security Agenda.

Thanks again for joining us today and now we'll open the lines for questions.

TOM SKINNER: Okay, Rebecca, I think we're ready for questions, please.

OPERATOR: Thank you, we will begin the question and answer session. If you would like ask a question, press star one and clearly record your name. First, Caelainn Hogan from The Washington Post.

CAELAINN HOGAN: How are the new infections affect foreign national staff working on the ground in West Africa or the international response of the epidemic?

STEPHAN MONROE: I'm sorry, how do these infections affect staff?

CAELAINN HOGAN: Yes, U.S. staff working on the ground in West Africa, are there protections in place or scale up for resources for doctors to protect themselves?

STEPHAN MONROE: Well CDC is working with other partners to try to make sure that all of the people providing direct care for Ebola patients in the region have the appropriate personal protective equipment and training in order to use that, to protect themselves.

CAELAINN HOGAN: and as of yet there is no such travel restrictions in the region and just trying to prevent the spread of the virus?

STEPHAN MONROE: yes, so for right now we're issuing our level two alert which recommends that people in the region avoid any contact with infected persons and particularly with blood or other body secretions.

TOM SKINNER: Next question, Rebecca?

OPERATOR: Our next question, one moment. Mike Stobbe with the Associated Press.

MIKE STOBBE: Thank you, doctor could you talk about what a level two travel advisory is? How many levels are there? Is two just one above no advisory, or what does it mean exactly? And I have a follow up.

TOM SKINNER: This is Tom Skinner. Marty Cetron has joined us, we'll let him answer this.

MARTY CETRON: I'm the director for Global Migration and Quarantine where the traveler's health sits. And Mike, level one is a watch which is practice usual precautions around outbreaks. Level two is an alert which is enhanced precautions. In this case, special recommendations either to populations at risk, such as health care workers or humanitarian aide workers or particular areas where the risk is high that goes beyond just a routine outbreak. Level three is a warning which is to avoid nonessential travel if you don't have a reason to be there. Those are the levels that we have.

MIKE STOBBE: Thank you, the follow up, is anyone from the U.S. government or from other governments at the airports watching passengers to see if they're exhibiting symptoms before they get on a plane?

MARTY CETRON: So right now there is a lot of discussion, there was an announcement from Liberia about scaling up a government response to include exit and entry screening and other measures. And the idea of whether additional border based controls controlling entry and exist points so that the screening can be more effective is actively under discussion by the international response community.

OPERATOR: Our next question comes from Maggie Fox with NBC News.

MAGGIE FOX: Number one do to feel like the authorities in Nigeria are equipped to do all the contract tracing needed, and is the incubation period and the contagiousness for the disease. There was one report about the guy whose sperm showed live virus for 61 days and I think there are still questions about people transferring the disease if they are asymptomatic.

STEPHAN MONROE: The second question has to do with the incubation period. The average incubation period is eight to ten days from exposure to onset of symptoms. The range is from two to 21 days. That's why we recommend that contacts of an infected person go on a fever watch for 21 days. We are aware of the report of the extended secretion of virus in semen, but in that case, there was no evidence of infectious in blood or other bodily fluids. So we're not as concerned about transmission from blood and body fluids– we do recommend that people use condoms and other barrier cautions. Use a condom for a follow up period after they have recovered. To the first question of the contact tracing going on in Nigeria, the CDC has staff in Nigeria who were there for other reasons that have gone to Lagos to assist along with the Nigeria Administration of Health to set up that contact tracing.

MAGGIE FOX: May I confirm who is speaking?

STEPHAN MONROE: Steve Monroe.

MAGGIE FOX: thank you.

OPERATOR: Our next question comes from Caleb Hellerman with CNN.

CALEB HELLERMAN: Hi, thanks for taking the question. I have a two parter. I'm curious, do you know how many or an approximate account of how many American health care and aide workers are responding to this outbreak. I'm also curious, you mentioned one of the patients only had fever and no other symptoms, how unusual is it to be that lightly symptomatic.

STEPHAN MONROE: We don't really have data on the number of U.S. nationals that are in these countries that are involved in humanitarian or other kinds of activities. So the second question, I mean there is a range of symptoms that are seen with Ebola. And the brain hemorrhage often associated with the illness in the popular media is seen in only roughly 50 percent of the cases. Many of the cases don't present with bleeding. So that makes the diagnosis more difficult at the early presentation because it can be easily confused with other diseases in the area like malaria and lassa fever and others.

TOM SKINNER: do you have a follow up?

CALEB HELLERMAN: no, thank you.

TOM SKINNER: next question, Rebecca?

OPERATOR: It comes from Jacob Ward with Al Jazeera America.

JACOB WARD: There are reports of the passenger that turned himself in in Lagos and then passed away was experiencing diarrhea during the flight. Given what you know of the disease, I'm curious if it falls into the category of direct contact if he had diarrhea in the restroom on the airplane. And also, the other workers were reported to have been following precautions and wearing the protective equipment, could you speculate or tell us about what the margin of error is that could cause someone to contract the disease even if they were wearing PPE? Thanks.

STEPHAN MONROE: Steve Monroe speaking again. The answer to both of your questions is basically we don't know. To the first question, we have not heard directly of reports of what kind of symptoms a patient may have had on the airplane. So we can't comment on if there were direct exposures that occurred on the airplane. As to the exposures that the two health care workers may have had, again what we know is that the physician was involved with direct patient care in the isolation wards and outside of the isolation ward. We don't know at this point where his exposure may have occurred, but it certainly reinforces the need for everyone to maintain strict adherence.

JACOB WARD: If I could follow up quick, the direct contact, if you could define direct contact. That truly means you're physically touch it, not in the same room with it or with the bodily secretions or anything like that, it's actually having to touch it?

STEPHAN MONROE: That's correct. Touching it and introducing it through some sort of mucus membrane or unbroken skin, a cut on the skin, something like that.

JACOB WARD: Great, thank you.

OPERATOR: We have Alice Park with Time.

ALICE PARK: I wanted to follow up more on the airport screening. Can you give us a sense of what they would involve, for example if they were to be instituted here in the United States, what would you be looking for? Fever? Could you clarify a little bit what that would be and how you would distinguish, you mentioned that, how would you distinguish them from other things you would not need to be as concerned about.

MARTY CETRON: This is Marty Cetron. You're raising all good points. I want to clarify that the airport based screening that I referred to earlier was exit screening from areas of the source, not entry screening here in the U.S. When this has been evaluated, the yield is much, much greater to try to control the disease at the source, and control the screening and right close to the source. The vast majority of flights from this region to the United States are indirect, they don't directly fly from these countries to the U.S., with few exceptions. The more you move through many other hub areas the more that gets diluted. The yield of fever being predictive of Ebola starts to go goes way, way down. So the kinds of measures that are in discussion right now are close to the scene of the epidemic.

ALICE PARK: I believe there are reports that Nigeria is beginning to institute some airport screenings. What, to your knowledge does that involve?

MARTY CETRON: It could be a whole spectrum of activities that could be associated with border controls. It could involve temperature checks, people filling out questionnaires regarding symptoms and exposure, they might involve certain border crossings being closed to assure that people are moving between countries through patrolled or health screened ports. There is a whole variety. I don't know exactly what each of the countries in the area are contemplating or are currently engaging in.

STEPHAN MONROE: I think most important thing is reinforce at the source the importance of identifying contacts of cases and reinforcing to those contacts they should not be traveling in that 21 day window until it is clear they themselves are not going to become symptomatic.

OPERATOR: Next question is from Betsy McKay, Wall Street Journal.

BETSY MCKAY: I had questions for both of you. One more for Marty. Could you talk about the border closing that the Liberian government announced today, how often does a country close borders for an infectious disease, is it a good idea? And I wanted to ask about the family members of the doctor, the physician, on the 21-day fever watch? Are they under a quarantine of any kind?

MARTY CETRON: I think in general border closures for infectious diseases are quite uncommon. As you're aware with the new international health regulations, there is an international protocol for determining through emergency committees and decisions that are

made by panels of experts that make recommendations to the director general about use of temporary measures like border measures or screenings as a way to control epidemics. They're really only sort of called into play for very serious epidemics that require such measures. What I read from the announcement over the weekend from Liberia is that certain borders are being closed while other crossings are being opened and those are the ones able to implement their health exit screening and so on. I think in this case the closings are about trying to make sure the movement across borders can go through the screening procedure. We're really still trying to gather the details, specifically for a lot of the countries. Sometimes borders are closed by neighboring countries out of fear of introduction of disease. Perhaps more usefully borders are managed by country that's have the epidemic focus so the disease is not spread to its neighbors. You see both kinds of reactions occurring. Sometimes they're generated for political reasons that don't always make sound health benefits. I think those are the kind of discussions that go on in emergency committees with WHO.

BETSY MCKAY: Is it appropriate in this case for them to be closing or limiting the border at this point?

MARTY CETRON: I think it's premature and unwise for me from a distance to comment on the wisdoms of the measures in country.

BETSY MCKAY: Okay, thanks. And then, for your–

STEPHAN MONROE: Your first question, we're not aware that the family members are under any sort of enforced, strict quarantine, just that they're on a fever watch. I would re-emphasize that people are not infectious prior to becoming symptomatic.

BETSY MCKAY: Thanks very much.

TOM SKINNER: Next question, Rebecca?

OPERATOR: We have Marie French, with Bloomberg.

MARIE FRENCH: Hello, I was wondering if one of you could address the issue of panic and misinformation in these countries about the disease and what efforts are being done to make sure that people are not panicking but also are taking proper precautions.

STEPHAN MONROE: Steve Monroe speaking. That's a real serious issue in all three of these countries. There is a fair amount of distrust of the government in general and of the messages being delivered. So what we're focusing on now is trying to identify in each one of the communities that are affected by this outbreak, the trusted source, whether it be an elder or religious leader, someone that we can work with to teach them first what the appropriate messages are so that people can then accept the messages. Because there is a fair bit of distrust and anxiety, naturally, among these communities. It's leading some people to not have their family members go to the isolation facilities and it's just extending the outbreak.

TOM SKINNER: Do you have a follow up?

MARIE FRENCH: In terms of the two workers who were infected, did they have any specific

training in dealing with infectious diseases? What training and knowledge did they have to make sure?

STEPHAN MONROE: Both of the people had been in the region providing humanitarian assistance prior to the Ebola outbreak in a medical setting. So they had training that was associated with that. Before they specifically were engaged with the care of Ebola patients, they were trained by Medicines sans Frontiers, Doctors without Border, who has a large amount of experience in dealing with patient care in Ebola outbreaks.

OPERATOR: Our next question comes from Linord Moudor with Voice of America.

LINORD MOUDOR: Hello, my question relates to prevention and treatment. A number of vaccines are in various stages of development and a range of organizations and a number of therapies are in the works. Some people argue that an outbreak is the perfect time to try them. Given the extent of this outbreak, and the uncertainty as to when it could be contained, isn't it time to test experimental vaccines and experimental therapy?

STEPHAN MONROE: There are, as you point out, a number of groups working on various kinds of treatments and vaccines to be used prior to exposure. None of them have been evaluated thoroughly, either here in the U.S. by the FDA or by any other regulatory organization in any other country. And so unfortunately none of these products are at the point where they could be used safely in this kind of environment. And so we're not recommending the use of experimental therapies or vaccination at this time.

LINORD MOUDOR: Okay.

OPERATOR: Our next question comes from Michele Marill with Hospital Employee Health Newsletter.

MICHELE MARILL: Thank you, I wanted to elaborate on health care workers and their exposure. Typically with bloodborne diseases you have to have a needle stick or something fairly significant. In this case is it sufficient to aspirate fluids, in which case if someone is vomiting and you're not wearing a respirator, you might be at risk? Or do we have any idea if there was a breach in infection control? There has been a large number of healthcare workers becoming infected and unless there are a lot of needlesticks, they don't have safety devices, I'm just wondering what might have lead to these healthcare worker exposures.

STEPHAN MONROE: I think there is two parts to your question. One is the health care workers operating in these clinics in Africa. The other is perhaps concern among health care workers here in the U.S. As you might imagine, the kinds of mechanical support and other things available in these clinics in Africa is fairly rudimentary. Most of the exposure to patients is through, potential exposures, is through needle sticks and things like that in collecting specimens and in disposing of bodily fluids if the patients have vomiting or diarrhea. In terms of healthcare workers in the U.S., it's instructive to look at the few cases there has been infected people with Ebola or Marburg virus, who have been treated in western health care settings. One here in the U.S. and one in the Netherlands a few years ago. In both of those cases the patients presented to the healthcare system before it was identified that they had the Marburg virus infection, but they were treated with standard barrier nursing and infection

control practices in the hospital. In neither case was there any evidence of health care associated transmission in those settings. While it's clear there is an increased risk for working with patients with Ebola, we're confident that the standard of care in the U.S. would prevent much of the transmission if a case were to show up here.

MICHELE MARILL: So you think needle sticks have maybe been the primary method of transmission of cases in Africa?

STEPHAN MONROE: I don't want to speculate, I don't think there has been a thorough review. It's not the kind of research protocol to look into the cause of infection. Fortunately early in the outbreaks before it is recognized that Ebola is responsible or in an area where they're not familiar as they are in these three countries, when dealing with Ebola outbreaks, a lot of the cases are among health care workers are just trying to care for sick patients and don't realize there is an increased risk.

MICHELE MARILL: One other question about the presenting to emergency rooms and the fact that the symptoms are fairly vague, they may be flu like, so that could be like a lot of diseases. We already have MERS where we're supposed to be asking travel questions. This would be travel questions. Should that be routine, should that be some kind of an alert for, you know, the health care providers about the possibility of an unusual disease.

MARTY CETRON: This is Marty Cetron again. You answered your own question. In globalization, I think that having a good travel history no matter, you know, whether or not you have an ongoing outbreak is a really key part of being an astute health care provider in any setting and being able to ask that history early in the process in an emergency room. In some ways, regardless of symptoms. As well as staying informed through traveler's health websites for what is going on in what regions of the world and having a very low threshold is just part of being well educated to practice medicine in a globalized world.

TOM SKINNER: Next question, Rebecca.

OPERATOR: Next comes from Helen Branswell with Canadian Press.

HELEN BRANSWELL: This is for Dr. Monroe, you started out saying this is probably going to be a marathon, does CDC have an idea of how long it thinks, if things go well, this might go on? I mean is this– is it possible that this might linger until the end of the year. I know often Ebola outbreaks are very hard to extinguish. What are you planning on? And also, sorry to ask a basic question, but what will it take to get this under control? How do you turn around communities and how do you essentially break the chains of transmission in such a difficult circumstance?

STEPHAN MONROE: All right, thank you. To the second question, you're right that the important thing, we know how to stop the outbreak, and that is to break the chains of transmission. What does that involve? First, identifying cases through active case finding and identifying all of their contacts who had contact with them during the time they were symptomatic and therefore are at risk of becoming infected themselves and following those contacts daily for 21 days and if they do develop symptoms to get them into isolation facilities. In terms of how long it will take, the standard with these Ebola outbreaks is to wait

42 days, two full incubation periods after the last case before declaring the outbreak is officially over. So if there was no cases identified after today, we would still be committed to waiting 42 days from today to declare in order to declare the outbreak fully over. The concern is that the outbreak can be reseeded much like a forest fire, with sparks from one tree reseeding it. That is clearly what happened in Liberia. Liberia was a situation they did not have any new cases for more than 21 days in the first wave of the outbreak and they were reseeded by cases coming across the border. Until we can identify and interrupt every chain of transmission, we will not be able to control the outbreak.

HELEN BRANSWELL: May I ask a quick follow up? I appreciate the information about the 42 days but what I'm wondering around is what– when you're sitting in the Emergency Operation Center, I'm sure you're sort of thinking about okay, the way this is going, this is likely going to last for awhile. What are you prepping yourselves to have to deal with?

STEPHAN MONROE: Well, we don't have an end date in mind. I think what I can say is that what we're trying to do is to approach this as a two-phase response here. Perhaps three because we already had phase one. In this phase, we want to, as quickly as possible, surge as many resources as we can into the area to try to get things going in all of these different areas where there is ongoing transmission. There is five or six districts in each country that seem to have cases, so it's geographically a challenge. But then recognize once we do that surge, we still have to maintain the effort over a long period of time. So we're developing rosters of people with appropriate skills, we have a new class of Epidemic Intelligence Service officers who just started so we're looking to engage them in the outbreak response as well.

TOM SKINNER: We have time for a few more questions, Rebecca.

OPERATOR: Next question comes from Maryn McKenna from Wired magazine.

MARYN MCKENNA: Both of my questions have to do with the possibility of import. In the MMWR archives, there are accounts of people coming to North America with active Lassa fever and being diagnosed and in one case dying, but the fever never spread, even to close contacts, can you draw any lessons or hope from that? Or is Lassa such a different from Ebola that those cases are not relevant.

MARTY CETRON: Maryn, that is a really good question. We are reassured by the multiple introductions of Lassa over the last two decades or so that there was not spread. It didn't preclude the very aggressive contact tracing and follow up and all kinds of things that Dr. Monroe and others have talked about. But it is reassuring that it is not that easily spread in a typical airline environment. While those cases were sick, there wasn't a lot of bodily secretion contamination in the travel environment that we're aware of and that is quite important. It is also a different virus and I don't think we would want to be overly confident about how we manage it and we would take the same abundance of caution in working up any potential introduction but it is reassuring.

MARYN MCKENNA: Thanks, my follow up has to do with, this is building on Michelle's question earlier. I hypothesize that there is someone in the U.S. who has been infected and they go for care to an ER, generally speaking travel history is typically is the first thing they're

asking. So I'm curious as whether part of what you're pushing out to health professionals, are you asking for changes in ER protocol?

STEPHAN MONROE: So I think you're right on target there. I think the point is to raise the level of awareness in emergency rooms and all of the front line places for primary care to ask the risk factor questions and assess symptoms in the context of what's going on globally. But also as part of a more universal approach to infection control. Sometimes that's easier to do in the setting of an internationally popular outbreak that's well publicized, but we don't want people to get complacent and forget about that in routine. We will use all sorts of methods that we have in educating providers to remind them of the importance of that message.

TOM SKINNER: Next question, please?

OPERATOR: Next comes from Jon LaPook with CBS Evening News.

JON LAPOOK: How important is the lack of resources or supplies in the outbreak? And how available is testing for Ebola in the U.S.?

STEPHAN MONROE: Steve Monroe speaking. To the first question for lack of resources. One of the things we worked on over the last two weeks within the U.S. government as a whole is have a whole of government approach to the requests coming in from various places in the region whether they're coming directly from the ministry of health or where groups are contacting our ambassadors or missions in the region, so those requests can be collated and triaged and we can find the appropriate resources to get back to people. Clearly what we call PPE, personal protective equipment, is one of the needs for the many health care workers who are engaged with direct patient care. In terms of testing in the U.S., there are no commercial labs I'm aware of that provide testing for Ebola virus. We have testing capability here at CDC and through the Department of Defense Laboratory at Fort Dietrich in Maryland.

JON LAPOOK: In terms of the lack of resources, would you say that that is a factor in people, in the spread of it right now. The fact that health care workers don't have, I know what you'll try to do but right now do they have enough equipment or is the lack of it one of the reasons that it is spreading?

STEPHAN MONROE: It's really difficult to say at this point. I think this issue of health education and community awareness is a critical piece leading to the ongoing transmission in the communities.

JON LAPOOK: How are the efforts with the village elders and religious leaders going? Is it too early?

STEPHAN MONROE: It's variable from place to place, and it's too early, until we get all of the fires put out, there is always a possibility that it will reignite.

JON LAPOOK: Okay, thanks.

TOM SKINNER: We've got time for two more questions very quick.

OPERATOR: Denise Grady with the New York Times.

DENISE GRADY: You mentioned that you have more officers from the CDC coming in. And I'm wondering if you have a time limit on what, how long people can stay when they are sent into these places to work? Do they rotate in and out? How does it work? Thanks.

STEPHAN MONROE: So the typical deployment is for 30 days, which is governed in part by Department of State regulations on how long someone can be officially deployed in the field. We're trying to rotate people in on basically a 30-day schedule.

DENISE GRADY: Is there some safety reason for that, also, just in terms of how long a person ought to be doing this kind of work that they're doing in a region like this. I mean when there is, if they're working in areas where there are lots of patients infected?

STEPHAN MONROE: Right, we're certainly concerned about the resilience of our own staff. So we try to make sure that people who are deployed have opportunities for down time during the time they're deployed. I should emphasize that at the current time, no CDC personnel are involved in any direct patient care in any of these facilities. We're more involved with this national level coordination and the database management system that's important for the case identification and contact tracing.

DENISE GRADY: Thank you.

STEPHAN MONROE: Okay, thank you all for your participation today. I just want to close by saying if we ever needed a reminder that we're all living in a connected world, this horrific Ebola outbreak in West Africa is it. Fundamentally to stop Ebola, we need to work together to do three things. These things are 100 percent in line with the global health security agenda. First we need to build systems to find cases quickly, before they spread. And when healthcare can make a difference between life and death. This means stronger health systems throughout the region, involving traditional healers, supporting primary care and supported by accurate laboratory testing. Second, we need to respond effectively by isolating cases, tracking contacts meticulously and managing the response through Emergency Operation Centers which every country should have. Third, we need to prevent future cases through meticulous infection control, safe burial practices, prompt diagnosis and isolation of new cases and better understanding of how this dreadful disease first crosses over from animals to humans so we can prevent this from happening. Thank you all for your attention.

TOM SKINNER: This concluding our telebriefing. Thank you all for joining us today. If you have follow up questions you may call the CDC press off at 404-639-3286. A transcript will be available as soon as possible.

OPERATOR: Thank you all for attending today's conference, you may now disconnect.

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES